Tricuro Ltd

Sidney Gale House

Inspection report

Flood Lane
Bridport
Dorset
DT6 3QG

Date of inspection visit:
11 August 2017
17 August 2017
29 August 2017

Date of publication:
27 March 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This was a responsive unannounced comprehensive inspection on 11, 17 and 29 August 2017. The inspection was in response to serious safeguarding allegations received by the local authority safeguarding team. The information shared with CQC about the allegation of abuse indicated potential concerns about the management of risks including safeguarding, staff recruitment and the overall management of the home.

At the last inspection in January 2017, overall the home was rated 'Requires Improvement'. The 'Is the service safe' was rated requires improvement and 'Is the service well led' was rated requires improvement. There were no breaches of the regulations at the last inspection.

There was a registered manager employed at the home but they were not at work during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Sidney Gale House is a care home without nursing for up to 44 older people. At the time of the inspection there were 34 people living or staying at the home.

At this inspection we found new shortfalls and seven breaches of the regulations.

The home is rated as 'Inadequate' and the service has been placed into 'special measures'.

Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, are inspected again within six months of the publication of the last report. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

People told us they felt safe. However, people were not consistently kept safe following making an allegation of abuse. This was because the adult safeguarding procedures in place were not followed. This potentially placed people at risk of further harm or abuse. This was a breach of the regulations.

Risks to some people were not consistently assessed or managed to keep them safe. People particularly at risk were those people living with dementia, those with specialist diets and those people with complex mental health needs and behaviours. This was a breach of the regulations.

Staff were not recruited safely because there was not a full record of staff's employment history. Sufficient information was not obtained for agency staff to make sure they were suitable and safe to work with people at the home. This was a breach of the regulations.

People's rights were not protected because staff had not acted in accordance with the Mental Capacity Act 2005 (MCA). This was a breach of the regulations.

The home was not well-led and there was not an open and transparent management culture at the home. There was not a culture of sharing information and learning from incidents, concerns or allegations to inform changes in practice to improve the service people received. The provider's quality assurance systems had not identified the shortfalls we found for people or driven improvements in the service provided. This was a breach of the regulations.

CQC had not been notified of significant events including allegations of abuse as required. We have issued a fixed penalty notice for this breach of the regulations.

We have taken enforcement action in response to the failings in relation to the breach of regulations for safeguarding people from abuse, the safe recruitment of staff and good governance. We have cancelled the manager's registration with CQC.

Overall, people received the care and support they needed and in ways they preferred. However, their needs and preferences were not consistently assessed or planned for. This was a breach of the regulations.

There were enough staff on duty to meet people's needs and permanent and longstanding agency staff knew people well as individuals and what their care and support needs were.

People told us staff were kind, caring and compassionate and they knew most of the staff. Staff spoke knowledgeably about people in ways which showed they valued and cared about them. Staff supported people patiently and kindly and did not appear rushed. People were treated with dignity and respect.

People were supported to make choices about their day to day lives and staff respected their wishes. People spoke highly of the activities on offer at the home.

People knew how to complain. No-one raised any concerns or complaints with us.

The provider was very responsive and took immediate action to ensure people's safety once the shortfalls were identified. They acknowledged that their current quality assurance monitoring systems and reviews had not identified the shortfalls found at this inspection. They told us they will now be reviewing all of their quality assurance and monitoring systems and implementing changes to identify and address such shortfalls in the future.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

People were not kept safe at the home.

People were not protected from the risk of abuse.

Risks to people were not consistently managed to make sure they received the correct care and support they needed.

There were enough staff on duty but they were not recruited safely.

Is the service effective?

Requires Improvement

People's needs were not always effectively met. This was because people's rights were not protected.

People enjoyed the food provided. However, some people's nutrition and hydration needs were not effectively monitored or met.

Most staff had not received dementia care training so they were able to meet the needs of those people living with dementia.

People's health care needs were met.

Is the service caring?

Requires Improvement

The service was caring but improvements were needed in relation to recording and assessing people's personal preferences.

People told us staff were caring.

Staff understood how to provide care in a dignified manner and respected people's right to privacy.

Family and friends were made welcome and continued to play a part in their family member's care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive to people and their needs and needed to be improved.

People did not have their pain assessed; their care plans were not always accurate and did not include sufficient information about their care and support needs. This meant staff did not have up to date information about how to care for people.

People and relatives knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

There was not an open and transparent culture and the systems in place to monitor the quality and safety of the service and drive forward improvements were not effective.

Notifications had not been made to CQC.

Sidney Gale House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was in response to serious safeguarding allegations received by the local authority safeguarding team. The information shared with CQC about the allegation of abuse indicated potential concerns about the management of risks including safeguarding, staffing and staff recruitment. This inspection examined those risks.

This inspection took place on 11, 17 and 29 August 2017 and was unannounced. The inspection was conducted by two inspectors on the first day and one inspector on the second and third day.

We spoke with and met all of the people at the home. We also spoke with six staff, four agency members of staff, six duty managers, two operations managers, the new acting manager and the managing director.

We looked at specific elements of four people's care, health and support records and care monitoring records. We looked at 10 people's medication administration records and documents about how the service was managed. These included five staff recruitment files, agency staff profiles and the staff training records, audits, meeting minutes, maintenance records and quality assurance records.

Before our inspection, we reviewed all the information we held about the service. This included the information about incidents the registered manager notified us of.

Following the inspection, the operations managers sent us the information we requested about the quality assurance systems, staff training and policies and procedures.

Inadequate

Is the service safe?

Our findings

There were adult safeguarding procedures in place that gave staff and managers clear directions as to what actions to take in response to any allegations of abuse being made. However, the management of adult safeguarding allegations at the home were not safe and had not protected people from potential harm. This was because two allegations of abuse were not reported to the local authority adult safeguarding team, and/or to the police and to CQC as required. In addition, the allegations were not appropriately managed, accurately recorded or investigated. The actions taken and responses by the management team potentially placed some people at further risk of harm and compromised any investigations by the local authority safeguarding team and police. Actions to keep people safe were not consistently implemented to mitigate the ongoing risks to people and to safeguard those people from further abuse.

There was a lack of oversight and management of these allegations of abuse at the home by the management at the home. The details of these allegations of abuse were not shared with the provider by the management team or identified during any provider visits to the home.

We identified these shortfalls and the ongoing risks to people to the provider's managing director and operations manager on the first day of the inspection. They agreed to implement an immediate plan to mitigate the potential risks to people whilst they undertook an internal investigation. By the second day of the inspection all staff and the duty managers had been given clear guidance, new safeguarding recording formats and a flow chart to follow in relation to reporting any allegations of abuse. Duty managers confirmed they had met with the operations managers and had been given clear recorded guidance.

Staff were trained in identifying and reporting allegations of abuse. Staff told us there was a good open culture of reporting any allegations. They said they reported any allegations to the management team who would then take the necessary action to report the allegations to either the local authority or police. However, staff were not aware of the outcomes of any safeguarding allegations. Any learning or changes in practice following any investigations were not shared with the staff team to minimise the risks of reoccurrence.

The acting and operations manager told us people were given information on how to report any concerns, worries and allegations of abuse in their welcome pack when they first moved in. However, there was not any easily available information for people and or their representatives about how to report any allegations of abuse displayed in the home. The acting and operations manager took immediate action to display the information for people and or their representatives.

These shortfalls in keeping people safe and reporting safeguarding allegations were a breach of regulation 13 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 18 Care Quality Commission (Registration) Regulations 2009.

People told us they felt safe and there were positive relationships between people and staff. People and staff smiled and chatted with each other. Staff supported and cared for people in a safe way as described in

their risk management and care plans. For example, staff safely moved one person in hoist. The person told us they felt safe, smiled and said the staff knew what they were doing. Staff chatted to the person and explained to the person throughout what they were doing.

People had risk assessments and management plans in place for their mobility, nutrition and falls. However, risks to some people were not consistently assessed or managed to keep them safe. We reviewed the risk assessments and management plans in place for one person, following the person raising an allegation of abuse. The risk management plan did not accurately assess the risks and the management plans put in place did not include the details of how safe support was to be provided to the person. For example, staff told us that the person did not wish to be supported or cared for by male staff but this was not reflected or detailed in their risk management plan. Staff told us that there were some circumstances where a senior male member of staff was required to observe the person taking a specialist medicine from a second female member of staff. During this observation the male staff member stood in the person's bedroom door whilst they took their medicines. This was not detailed in the person's risk management plan and other options of respecting the person's wishes in relation to not being supported by male staff had not been fully explored.

Another person was at risk of choking and had a risk management plan in place written by a speech and language therapist (SALT). This plan included the person needed a soft diet and they could not safely eat crumbly foods such as toast and dry cake. This reflected what the care staff told us the person could eat and what consistency foods were required to be to ensure they could safely eat without coughing or choking. However, one member of staff gave the person a biscuit. We raised this person's risk of choking with the operations and duty manager who took immediate action to ensure all activities staff were given a summary of people's specific dietary needs.

This person was also assessed as at a high risk of falls and they had a pressure alarm mat placed in front of them, to alert staff if the person tried to mobilise independently. However, staff and the person told us they did not mobilise independently, would make no attempt to stand up and required staff to assist them to move by using aids such as a hoist. This person had not had any falls since November 2015. This meant the risk assessment and management plan was not accurate. The pressure alarm mat in use potentially introduced the additional risk of people tripping because there were trailing wires, the mat was a different colour to the carpet (and may appear as a black hole with impaired sight to those people living with dementia) and was not flush with the floor.

A third person had also been identified at high risk of falls. As part of the risk management plan to minimise the risks they had a pressure alarm mat placed by their bed at night. However, the use of the pressure alarm mat had not been effective in minimising the risk of falls as the person had continued to fall over even though the pressure alarm mat was in place.

This person was living with dementia and had a diagnosed mental health condition. When they were upset and anxious they presented some behaviours and challenges to themselves, to other people, staff and the environment. We observed both permanent and agency staff providing the person with support in a calm, reassuring and sensitive way. All the staff we spoke with were able to describe how they supported the person when they were upset or anxious. They confirmed information about how to support them was shared at staff handovers. However, this was not recorded in any positive behaviour support risk management plan so the person benefitted from a consistent approach by staff. Mental Health professionals and a speech and language therapist had been involved with the person and provided the person and staff with guidance and support, some of which the person had chosen not to follow or use. However, this guidance was also not reflected in any positive behaviour support risk management plan.

These shortfalls in fully and consistently assessing and mitigating the risks to people receiving care were a breach of regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the first day of inspection the operations managers reviewed the use of pressure alarm mats for people. Those pressure alarm mats in use where they either did not minimise the risks or presented additional risks to people were taken out of use. New movement sensors had been ordered for those people where the sensors would mitigate the risks for the individuals.

Other elements of risks to some people were fully assessed and well managed. For example, on the first day of the inspection one person had a very low mood and had expressed thoughts about harming themselves. The duty manager referred the person to their GP, the safeguarding team and reviewed and updated their risk assessment and plan. They ensured their immediate environment did not contain anything that they could use to potentially harm themselves.

Another person had a skin integrity risk management plan in place that included they needed to sit on a specialist pressure relieving cushion. Throughout the inspection the person was sat on this cushion in both their wheelchair and armchair.

For a third person there was a risk assessment and management plan in place in relation to them becoming upset with other people and then potentially making physical contact with them. The risk management plan detailed the risks and how staff were to positively support the individual if they became upset with other people.

At our last inspection in January 2017 we identified that there was a high use of agency staff at the home. It was recommended that the provider ensured that all staff new to the home, permanent or otherwise have the opportunity for an induction that provided them with sufficient information to meet the needs of the people they support. However, on the first day of the inspection, staff said when new agency staff started working they still needed to explain to the agency staff what care and support people needed. One staff member told us, "New agency staff makes life very hard" but said that when regular agency staff were used people's needs were better met. Staff told us new agency staff were now having an induction when they first attended the home. Following our feedback on the first day of inspection, a new handover record was implemented and this meant agency staff had a summary of the people's needs who they would be working with. One agency member of staff told us, "The new handover records are brilliant" and they have made, "A world of difference because now we have all of the basic important information about people".

The operations managers told us there was a recruitment plan in place and the new manager would be focusing on the recruitment of permanent staff when they started work at the home.

We reviewed the information and induction records for the 15 agency staff who had worked at the home since June 2017. There were eight of the agency staff profiles that did not include a photograph. There was also no record of how staff at the home were verifying agency staff's identity and whether they had seen a copy of the agency staff's Disclosure and Barring Service (DBS) check. There were no agency staff profiles or information held for four of the agency staff that had worked at the home. By the second day of inspection all of the agency staff information was available. In addition, a new system of checking the identity and DBS for new agency staff had been implemented by the provider.

There was a bank staff member who also worked at another of the provider's home and their recruitment file was in the other home. This meant there was not any information held at Sidney Gale House about this staff member. The operations manager agreed to make sure a copy of the staff member's file was also held

at Sidney Gale House.

We looked at the last four permanently recruited and one longstanding staff member's recruitment files. Records included a photograph of the staff member, proof of their identity, references, a health declaration and check had also been made with the DBS to make sure staff were suitable to work with people. However, there were shortfalls in establishing the four new staff's full employment history and in exploring any gaps in their previous employment. One member of staff recruited during 2015 did not have any employment history recorded on their staff file or job application. This meant there was not a record of staff's work history and that any gaps in employment had not been explored to make sure that staff were suitable to work with people living at Sidney Gale House.

These shortfalls in the recruitment of staff and obtaining information from the staffing agency were a breach of regulation 19 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the medicine storage and stock management systems in place for people. Medicines were stored safely. We checked the storage and stock for some specialist medicines and found the stock and the medicine record book balanced for those medicines.

We looked at the MAR (medicine administration records) and cream application records for 10 people. The records showed that people had their medicines and creams applied as prescribed. The cream application records only included a brief description of how often and where peoples' creams should be applied on their body. We discussed the use of body maps so staff could easily see where to apply the person's creams. This was because there was a high use of agency staff who would need easy to see and follow guidance as to where they needed to apply any prescribed creams. The duty manager and operations manager took immediate action and implemented the body map creams records supplied by the pharmacy.

Permanent staff and duty managers know people very well and were able to describe when they would administer any 'as needed' (PRN) medicines to people. There were PRN medicines plans in place but these did not fully describe the circumstances when to administer the PRN medicines to people. This meant that any unfamiliar or new agency staff may not recognise or know when to administer people's PRN medicines or creams. This was an area for improvement.

There was not a consistent way of staff recording when staff administered PRN medicines to people. The use of two different systems of recording meant it was difficult for staff to be able to easily review the person's use of any PRN medicines. This was an area for improvement.

There were enough staff on duty to meet people's needs. The provider and registered manager reviewed people's dependency on a monthly basis. The provider had increased the overall care staff hours earlier in 2017. This decision was based on the information gathered and the provider acted to make sure there were enough staff safely support and care for people.

Risks in relation to the building were managed, with contingency plans in place for emergencies. People had personal emergency evacuation plans, which provided staff with guidance on how to support people to safety quickly and efficiently when required. There were systems in place for the maintenance, reporting and monitoring of the building and equipment. This included the servicing of boilers, hoists, equipment and a legionella risk management plan.

Requires Improvement

Is the service effective?

Our findings

People's rights were not protected because staff had not consistently acted in accordance with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff were trained in the MCA but did not fully understand and implement the principles of the MCA. This was because MCA assessments were not consistently completed and no best interests decisions were recorded. For example, staff told us there was a best interests decision that had been made for one person in relation to eating in a communal area because of their risk of choking. There was a mental capacity assessment completed for the person that determined they did not have the capacity to make the decision about being observed whilst they were eating. However, there was no subsequent best interests decision recorded and other professionals and representatives had not been consulted about making the decision.

For some people who had been assessed as not having the capacity to consent to care and treatment they had signed their care plans and other documents. This meant they may not have understood what they were signing and consenting to. Some people's relatives or friends had signed to give consent to bedrails being put in place. However, these relatives or friends did not hold lasting power of attorney to make these decisions and these decisions should have been made in the person's best interests in line with the MCA.

These shortfalls were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us and staff sought people's consent before assisting them in any way. One person said, "They always check and ask me before they do anything". Where people had capacity to make decisions they told us and we saw examples which showed they had consented to their care planning.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The acting manager and duty managers understood when DoLS applications would be required and had made appropriate applications. The acting and duty managers told us that no-one currently had conditions attached to their DoLS authorisations. The acting manager planned to implement a system to ensure that any people's DoLS authorisations that were due to expire had early applications made.

Overall, people were supported to eat and drink as directed by their safe swallow plans written by their Speech and Language Therapist (SALT). People's weights were being monitored and reviewed on a monthly basis. People who were identified as nutritionally at risk were having their foods fortified (such as full fat cream, full fat milk, or full fat cheese added to their meals) to help increase their weight and their food intake

was monitored. The kitchen staff had clear information as to who needed any specialist diets such as diabetic diets, what texture and consistency of foods people needed and who needed to have their meals fortified.

One person had lost weight and a referral had been made to their GP and dietician for advice. This person's dietary plan identified that due to their weight loss they needed to be weighed weekly and have their food and fluids intake monitored. There were records of what the person had eaten and the kitchen staff confirmed the person was having a fortified diet. We observed the person eating and drinking during the inspection. However, the person had not been weighed weekly and there was not an accurate way of recording and monitoring what fluids the person was drinking. In addition, there was not a target amount of fluids or any system for totalling the amounts drank to make sure their person was drinking enough to keep them hydrated. The acting manager took immediate action and implemented a fluid intake and monitoring record.

One person, who was living with dementia, had a dietary plan that included they were to be given small meals. However, the person was given a very large meal and subsequently did not want to eat it. Staff offered the person a pudding which they ate.

Plain white or cream crockery was used throughout the home and these were placed on contrasting coloured table cloths. Specialist lipped/guarded plates were used so that people could eat independently. However, people living with dementia and or sight loss may have benefitted from eating and drinking from brightly contrasting coloured crockery. This is because research has shown the food and drinks are easier to see and people subsequently eat and drink more.

These shortfalls in meeting people's needs and preferences in relation to nutrition and hydration, and having regard to their wellbeing the were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke highly of the food and drinks provided. People were given a choice of two main meals, a vegetarian option or a salad. People chose their main meal each morning and were reminded of their choice at meal times. If people did not enjoy the meal an alternative was offered. For example, one person was not enjoying the rice with their curry so staff offered them curry and mashed potatoes. When the person did not like that they offered them casserole and mash. The person did not then fancy that either and requested a fruit smoothie and the kitchen made them a fresh fruit smoothie of their choice. The person told us the staff always tried to find them something they liked or fancied.

People's health needs were met. We saw examples of where people had been referred to the GP, district nurses and dieticians. People had access to chiropody services, opticians and dental care.

People told us they thought staff had the right skills and knowledge to carry out their roles. Staff received core training in subjects including moving and handling, first aid, food hygiene, MCA, infection control and safeguarding. However, only 24 of the 62 staff employed had received dementia awareness training. There were people living with dementia living or staying at the home and some of those people needed positive behaviour support from staff. Providing staff with dementia awareness and positive behaviour support training was identified at the last inspection and remains as an area for improvement.

We received mixed feedback on how staff felt about the support they received during one to one supervision sessions with their line manager. Staff who were supervised by the duty managers spoke highly of the support they received. Some other staff did not feel so well supported by their line managers. We reviewed

the supervision records for four staff who had different roles and responsibilities at the home. The provider had developed a standard supervision agenda to be covered during each session. However, all of the agenda items such safeguarding were not consistently covered in some staff's supervisions. This was an area for improvement.

The service had taken measures to aid people's ability to navigate and understand where they were within the home. There were brightly coloured hand rails, consistent flooring throughout the corridors and stairs, with dementia friendly signs on all communal doors including dining areas, bathrooms and toilets. There were individualised memory boxes on the ground floor alongside each bedroom door to help people identify their bedroom.

Requires Improvement

Is the service caring?

Our findings

People told us, observations we made and people's care records showed that overall people's preferences were met. However, this information was not consistently recorded or planned for. For example, one person's preference for female staff was recorded in their assessment, care plan and the information was included in staff handovers. However, another person who staff and the handover records confirmed only wanted female staff did not have this preference recorded in their assessment or care plan. This was an area for improvement.

Comments from people about the qualities and kindness of staff include: "It's nice to get to know the care staff they are kind", "They are ever so good, they help me stand up in the mornings and help me to have a wash", "They look after me well", and "The care here is good".

Staff interacted with people in a warm, relaxed and friendly way. People responded to staff by smiling and chatting with staff.

Staff knew people well and were able to anticipate their needs and understand their moods and emotions. For example, staff reassured and spoke calmly with one person, who was living with dementia, when they were upset and anxious. They were pulling at their clothes and wanted to leave the lounge but they were not able to verbalise this. Staff saw the person looked worried and quickly went over smiled at them and offered to accompany them out of the lounge.

Staff were respectful, understanding and patient when assisting people. They addressed people by name, responded promptly to requests and spoke to people at eye level, giving them time to respond to any questions.

People's independence was promoted. Staff encouraged people to mobilise independently by giving them time and encouragement to stand up and walk with their walking aids. People who wanted to assisted with clearing the tables after a meal and helped with the washing up.

People had access to advocacy services and some people had an advocate appointed as their Relevant Person's Representative (RPR). Their role was to maintain contact with the person, and to represent and support the person in all matters relating to any authorized DoLS.

The home had been accredited and achieved a 'commend award' in The Gold Standards Framework in End of Life Care. This is an accredited training programme and award that aims to result in a better quality of care, proactive planning, working with GPs, staff morale and more advance care planning for people.

There was no-one receiving end of life care at the time of the inspection. However, we reviewed the advanced end of life care plans and records for people. They had end of life care plans that gave staff important information that they would like to be followed at this time. For example, one person had detailed they did not wish to be admitted to hospital but to remain at the home.

Relatives had provided feedback and thank you letters to the staff team about the care received and positive experience of them and their family members at the end of their lives.

Requires Improvement

Is the service responsive?

Our findings

One person who had moved into the home the previous month had a seizure whilst they were in hospital. This information was recorded in the person's assessments but there was no plan in place as to what action staff would need to take if they had any further seizures. The acting manager took immediate action to implement a care plan so staff had clear information and a plan to follow if the person had a seizure.

Staff offered people pain relief when they administering their other medicines. However, those people who were living with dementia or did not communicate verbally did not have their pain assessed using any recognised pain assessment tool. These tools are used to assess people's pain levels if they cannot verbalise if they are in pain. This was important because people living with dementia may not always be able to say or show when they are in pain.

These shortfalls in assessing people's needs and care planning were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people's care plans did not include a photograph of the person and others included old photographs that did not reflect how the person currently looked. This was important because some people were living with dementia and at risk of leaving the home unsupervised. The acting manager took immediate action and arranged for photographs for the care plans that were reviewed. They also arranged for an audit of everyone else's care plans to check they had a current photograph.

Staff were very knowledgeable about people and were able to tell us about people as individuals and what their care, support, emotional and social care needs were and how these needs were met. Some elements of people's care plans included easy to follow guidance for staff and were personalised. There were details regarding people's life history and experiences. In addition for some people living with dementia a 'This is me' document had been completed. 'This is me' is a tool used to record details on the person's cultural and family background; events, people and places from their lives; preferences, routines and their personality.

People who were able to told us staff respected their preferences and they were involved in developing their care plans. People said staff reviewed their care plans with them every month and asked them to sign their plans if they agreed to the changes.

People told us and we saw they enjoyed the activities provided. People said there was enough to keep them occupied. Those people who chose to spend time in their bedrooms told us they were given the opportunity to join in group activities if they wanted to. During the inspection there was a visit from the donkey sanctuary, flower arranging, art, and patchwork. There were two activities co-ordinators who worked Monday to Friday. There was a planned programme of activities that was based on people's preferences and interests. People were given a copy of the flyer for the week's activities and this was also displayed on the notice boards.

There was a visiting clergy every week for those people who wished to participate in a Christian service. One

person told us they played the piano at the service every week.

Complaints leaflets were displayed in the main entrance to the home. People told us they knew how to complain. No-one raised any concerns or complaints with us. We reviewed the complaints records and there had been one complaint received since the last inspection. The complaint had been investigated in line with the complaint procedures.

Inadequate

Is the service well-led?

Our findings

The registered manager was not at work during the inspection. A new manager had been appointed prior to the inspection. The new manager was the registered manager at another of the provider's care homes. Following the first day of the inspection the management of the home was being covered by the provider's two operations managers and the new manager. It was planned for the newly appointed manager and operations managers to manage Sidney Gale House in the absence of the registered manager.

At our last inspection in January 2017 we identified some areas for improvement. This was because staff told us about the low staff morale at the home. Some staff told us that they felt supported by management, but others did not. The registered manager told us at the last inspection about the difficulties that the home was facing, particularly with recruitment and the changes to staff's terms and conditions and actions that were being taken to make improvements. We also identified that the quality assurance audits were not fully effective in identifying people's changing needs and whether their consent to care had been sought.

At this inspection, there was not an open, transparent, and learning management culture at the home. There were mixed responses as to whether staff felt able to raise concerns with managers and whether these concerns would be acted on and the outcomes shared. Staff knew how to whistleblow and raise concerns. However, from discussions with staff, a culture had developed of staff not raising concerns or identifying ways of improving the service. Staff told us they focused on getting to know people well and making sure people received good quality care and support. This was because these were the areas they were able to influence and manage on a day to day basis.

Staff told us they had confidence in the duty managers, they were well supported by them and there was a good culture of reporting any concerns, incidents and safeguarding allegations/concerns to the duty managers.

The duty managers reported any safeguarding concerns to the relevant safeguarding authority or the local authority out of hour's service. The duty managers told us they also reported any concerns directly to the registered manager who then managed the concerns with the reporting duty manager. However, these discussions or any actions agreed were not recorded so the information could be shared with the rest of the senior team.

There were monthly senior team meetings between the management team. We reviewed these minutes and they included information and updates about the management of the home from the registered manager and duty managers. However, these meetings did not include any sharing or reviewing of internal quality audits, compliments, complaints, safeguarding, accidents and incidents. This meant this information gathered was not used to prompt and influence changes in care practices or systems at the home. The results were not used to develop action plans to drive improvements in the quality and safety of the service or to improve the outcomes and experiences of people and staff.

Staff told us and minutes showed there were bi-monthly staff meetings. We reviewed the staff meeting

minutes since the last inspection. The minutes reflected there was not a well-led open, transparent, learning and no blame culture at the home. This was because the minutes showed that following the last inspection the management team had informed staff they were 'upset with the comments raised by staff re time shortages on residents' and the management team 'asked all staff to be mindful of their comments with inspectors in the future'.

There was not any formal recorded way of the management team sharing information about the day to day management of the home. This was particularly important because the majority of the duty managers worked part time and there would routinely be a number of days before they were next at work. This meant important information about people, staff and any accidents and incidents was not shared in an effective and robust way. Duty managers told us they relied on the brief information recorded on the handover records but this only related to people not to other day to day management issues. Following the first day of inspection the operation managers introduced a senior team communication book. This book included important handover information about the day to day management of the home. It directed duty managers to review specific people's records or care plans if their needs had changed and detailed any new management information and procedures. The duty managers told us this had already improved the communication and they felt listened to and informed about what was happening in the home.

There were bi-monthly 'residents' meeting that were chaired by the activities worker. During these meetings people were consulted about any upcoming social events and activities. These meetings were chaired by the activities workers. Any feedback from the meetings was shared with the appropriate staff. For example, any feedback about the food was shared with the kitchen team.

People, relatives, staff and professionals were asked to complete an annual internal satisfaction survey. We reviewed the completed surveys and overall they were positive about people's experiences at the home. However, there was not a consistent means of distributing the surveys so that everyone received a copy, they were not dated and had not been analysed on their return so any actions could be taken in response to any comments or low scores.

There was not a person centred culture at the service in relation to the management recording systems in place. People were not referred to by their names but by their room numbers in some management records such as resident, staff and senior meeting minutes, safeguarding, accident or incident records. This had led to some staff referring to individuals by their room number rather than using their names. From discussion with staff this culture had developed from a misunderstanding about the recording people's personal information and data protection in management records. By the second day of inspection the duty managers and staff were starting to use people's names rather than room numbers. Duty managers reminded staff to refer to people by their preferred names when sharing information with other staff.

Some staff had skills and knowledge that were not consistently valued or used to benefit the people who lived at Sidney Gale House. The duty managers had received management training from the provider, had management qualifications and some had specific skills such as dementia care mapping, which is a way of observing, assessing and identifying the wellbeing of people living with dementia. However, staff told us they were not supported and enabled by the management team to use these skills to improve the services provided at Sidney Gale House. For example, the use of a qualified dementia care mapper would have benefitted those people living with dementia. This is because the information gathered during the observation periods would assess and identify any unmet needs for people, identify ways staff could better support people's wellbeing and identify any staff training or development needs. However, a staff member with this and other nationally recognised dementia qualifications was not supported to use their skills at the home.

The provider had developed a programme of quality and safety audits. These were completed by the duty managers and or the registered manager. The registered manager was responsible for signing off monthly audits and checks which included auditing samples of care plans, medication records and checking people's bedrooms. The registered manager also signed off audits of accidents and incidents and building maintenance. They submitted statistical information and key performance indicators every month to the provider in relation to a range of information such as occupancy, referrals, staffing hours, people's dependency scores, safeguarding alerts and survey responses. There was also a programme of bi-monthly, quarterly and annual checks and audits that were completed by duty managers. We reviewed these records and they had been completed as required. However, there were no means of cross referencing the information submitted was accurate.

As part of the provider's quality assurance systems there were monthly visits by the provider's operations managers who met with the registered manager, people, some staff and reviewed a sample of people's and management records. These monthly records detailed the discussions with staff, people, the registered manager and the outcome of their checks on a sample of the records. The operations managers did not specifically look at all of the management records in place and were reliant on the registered manager keeping them updated with the details of any events, incidents or concerns at the home.

In addition to the operations managers visits there were quarterly peer audits completed by the provider's other registered managers. The last peer audit in July 2017 identified that safeguarding was not always discussed during staff supervisions. This was supported by the sample of the supervision records we looked at.

The operations managers told us, following the first day of the inspection, they and the provider were now reviewing the quality assurance visits and the records they would now examine when they visited the provider's services. This was because the existing quality assurance monitoring systems had not identified the concerns and shortfalls found at Sidney Gale House.

Any compliments received at the home were entered onto the provider's paper and electronic database and shared with the operations managers during their monthly visits. There had been 13 compliments received since our last inspection in January 2017. Staff told us compliment cards were placed in the notice board for the staff to see.

People's records were not consistently completed so there was an accurate, contemporaneous record for people. For example, the lack of detailed recording in relation to safeguarding allegations meant CQC and the local authority safeguarding teams were not able to establish sequences of events, who allegations were made to and how, why and by whom any decisions were made in relation to the allegations. There were also shortfalls in some records relating to the overall management of the service. This made it difficult to fully assess how well led the service was. This meant any learning or actions of how to improve the service and mitigate any risks were not identified and subsequently shared with staff. Other records, such as surveys to people, relatives, staff and professionals, were not dated to be able to identify during what time period they were completed.

The provider acknowledged that their current monitoring systems and reviews had not identified the shortfalls found at this inspection. They told us they will now be reviewing all of their quality assurance and monitoring systems and implementing changes to identify and address such shortfalls in the future. We recommend the provider continues to review and assess the effectiveness of their quality assurance systems.

The shortfalls record keeping and governance were a breach of regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC had not been notified of significant events, such as safeguarding allegations, as required by the regulations. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following the first day of the inspection the operations managers submitted notifications to CQC as required.

The service's CQC inspection rating was displayed as required in the front entrance of the home and on the provider's website.

The provider responded promptly to the concerns and shortfalls identified prior to and during the inspection to ensure the safety of people living at Sidney Gale House. The provider was co-operative, open and transparent and provided any information requested by CQC and or other professional bodies involved.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There were shortfalls in meeting people's needs and preferences in relation to nutrition and hydration, and having regard to their wellbeing. There were also shortfalls in assessing people's needs and their care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There were shortfalls in seeking people's consent. People's rights were not protected because staff had not consistently acted in accordance with the Mental Capacity Act 2005 (MCA).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were shortfalls in fully and consistently assessing and mitigating the risks to people receiving care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There were shortfalls in the recruitment of staff and obtaining recruitment information from the staffing agency to make sure they were suitable to work with vulnerable people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications of significant events were not made to CQC.

The enforcement action we took:

CQC has issued a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were shortfalls in keeping people safe and reporting safeguarding allegations. The provider's safeguarding policies and procedures were not followed

The enforcement action we took:

CQC has cancelled the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were shortfalls record keeping and the governance systems at the home.

The enforcement action we took:

CQC has cancelled the manager's registration.